Clear Form Entries

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Rehabilitation Supports

MEDICAL NECESSITY STATEMENT

Please Type or Print

Consumer's Name: _____

Date of Birth: _____

Social Security Number: _____

Medicaid #: _____

Medical Necessity Criteria for Rehabilitation Supports: The consumer is a Medicaid recipient and meets DDSN eligibility criteria, who needs to develop, retain or restore an optimal level of functioning in one or more of the following areas: Self-Care Skills; Community Living Skills; Psycho-Social Skills; and/or Medication Management / Symptom Reduction Skills; in order to enhance the consumer's capacity for personal independence essential for successful community living.

☐ **Approve.** I recommend that the above-named consumer be provided Rehabilitation Supports for the purposes of correcting or ameliorating physical or functional limitations and/or mental illnesses and/or other conditions which, if left untreated, would negatively impact the health and quality of life of the consumer. The consumer meets the medical necessity criteria for Rehabilitation Supports.

☐ **Deny.** I do not recommend that the above-named consumer be provided Rehabilitation Supports. The consumer does not meet the medical necessity criteria for Rehabilitation Supports.

_____ _____

Signature of Physician or Licensed Practitioner of the Healing Arts *Professional Title*

Please Type or Print

_____ _____

Name of Physician or Licensed Practitioner of the Healing Arts Date

_____

Address